

Case Number:	CM13-0028256		
Date Assigned:	11/22/2013	Date of Injury:	06/05/2012
Decision Date:	01/29/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 43-year-old male who reported an injury on 06/05/2012. The mechanism of injury was not provided. The patient's diagnoses were noted to include lumbar radiculopathy, L4-5 disc herniation, cervical radiculopathy, and C5-6, C6-7 disc herniation. The request was made for Combo Care 4 stimulator purchase (quantity 1), hot/cold contrast system with DVT compression purchase (quantity 1), shoulder home therapy kit purchase (quantity 1), and cervical home therapy kit purchase (quantity 1).

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Combo Care 4 Stimulator (purchase) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118, 115, 116, 120.

Decision rationale: California MTUS guidelines do not specifically address the Combo Care 4 Stimulator unit. However, it addresses the components. California MTUS does not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. California MTUS recommends a one

month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. California MTUS does not recommend NMES except as part of post stroke rehabilitation and further states that there is no evidence to support its use in chronic pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to California MTUS Guidelines. Given the above lack of documentation, the request for Combo Care 4 purchase, quantity 1 is not medically necessary.

Hot/Cold Contrast System with DVT/Compression (purchase) QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation and Official Disability Guidelines (ODG), Knee & Leg Chapter, Cryotherapy, Deep Vein Thrombosis, Low Back Chapter, Cold/Heat packs, online version.

Decision rationale: ACOEM Guidelines discuss application of cold in the acute phase, but does not address hot/cold contrast system with deep vein thrombosis/compression unit. California MTUS does not address hot/cold contrast system with deep vein thrombosis/compression unit. Official Disability Guidelines indicate that at home, local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days; including home use and they recommend patients who are at risk for developing venous thrombosis and indicate those patients should be treated prophylactically. Additionally it addresses compression garments in the form of compressions stockings to prevent DVT. The clinical documentation submitted for review failed to provide the necessity for the requested service. There was a lack of documentation indicating the patient had been assessed for risk of venous thrombosis. Given the above, the request for hot/cold contrast system with DVT/compression, purchase, quantity 1 is not medically necessary.

Shoulder home therapy kit (purchase) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, DME, online version.

Decision rationale: California MTUS and ACOEM Guidelines do not address durable medical equipment. Per Official Disability Guidelines, durable medical equipment is recommended if

there is a medical need and if the device or system meets Medicare's definition of durable medical equipment below. The term DME is defined as durable medical equipment, which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. The clinical documentation submitted for review failed to provide what item was being requested in particular for the shoulder home therapy kit per the submitted request. Given the above and the lack of documentation, the request for shoulder home therapy kit purchase, quantity 1 is not medically necessary.

Cervical home therapy kit (purchase) QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, DME, online version.

Decision rationale: California MTUS and ACOEM Guidelines do not address durable medical equipment. Per Official Disability Guidelines, durable medical equipment is recommended if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment below. The term DME is defined as durable medical equipment, which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. The clinical documentation submitted for review failed to provide what item (s) were being requested in particular for the cervical home therapy kit per the submitted request. Given the above and the lack of documentation, the request for cervical home therapy kit purchase, quantity 1 is not medically necessary.